The California Managed Risk Medical Insurance Board
PO Box 2769
Sacramento, CA 95812-2769
(916) 324-4695 FAX: (916) 324-4878

Managed Risk Medical Insurance Board

HFP Advisory Panel Meeting Summary
May 30, 2013
Sacramento, California

Members: Jack Campana; David Rivera; Karen Lauterbach; Jan Schumann; Paul Phinney, M.D.; Elizabeth Stanley-Salazar; Ronald DiLuigi; Liliya Walsh; and William Arroyo, M.D.

MRMIB Staff: Janette Casillas, Executive Director; Ernesto Sanchez, Deputy Director, Eligibility, Enrollment and Marketing Division; Ellen Badley, Deputy Director, Benefits and Quality Monitoring Division; Alexa Malik; Valerie York; and Felipe Ybarra.

Other Attendees: Clarissa Pool-Sims, Medi-Cal Eligibility Division, Department of Health Care Services; Javier Portela Managed Care Division, DHCS; Fei Collier, Project Manager, DHCS; and Kristine Marck, California Medical Association.

Introductions

Jack Campana, Healthy Families Program (HFP) Advisory Panel Chair, opened the meeting by thanking the Department of Health Care Services (DHCS) for providing a new location. Mr. Campana introduced himself and asked the Panel Members and the Managed Risk Medical Insurance Board (MRMIB) staff and audience to introduce themselves. Ernesto Sanchez, Deputy Director at MRMIB, administered the oath to Paul Phinney, M.D.

Review and Approval of February 21, 2013, HFP Advisory Panel Meeting Summary

The HFP Advisory Panel reviewed the February 21, 2013, meeting summary. No edits were made and the summary was approved.

State Budget Update

HFP Current Year Budget Shortfall

Ernesto Sanchez, Deputy Director, reminded the panel HFP has a current year shortfall; the budget finalized last July assumed revenue from the Managed Care Organization (MCO) tax but the bill did not pass. MRMIB currently has a deficiency of $128 million in State funds. With the $128 million, MRMIB would draw down $238 million in federal

matching funds for a total deficiency of $366 million. MRMIB currently owes the HFP health plans and the administrative vendor from December 2012 through May 2013 a total of $282 million.

May Revision
Mr. Sanchez stated the Governor's May Revise included a proposed extension of the MCO tax that would provide MRMIB with the $128 million shortfall. The May Revise has MRMIB operating until end of Fiscal Year 2013-14. As of July 1, 2014, the Board would be dissolved and any remaining responsibilities will be transitioned to DHCS. MRMIB staff will transition to either DHCS or the Health Benefit Exchange Board (HBEx).

Analysis of Governor's Proposed Budget by the Legislative Analyst Office
Mr. Sanchez presented the Legislative Analyst Office (LAO)'s Analysis and highlighted that HFP transition has gone mostly as planned and provides changes in the savings estimates due to delays in the transition.

Transition of HFP Subscribers to the Medi-Cal Program

Update on Transitioned Children to the Medi-Cal Program
Mr. Sanchez stated this document lists observations and recommendations on the transition and discusses the number of children moved in different phases. There are now around 154,000 children left in the HFP. MRMIB recommends required reports from DHCS include feedback received at the Department of Managed Health Care (DMHC) HMO hotline and some of the data received at the Single Point of Entry (SPE). There have been a number of issues related to mental health services, particularly with comparison of required services. The HFP was subject to health parity laws while the Medi-Cal Program is exempt.

Ms. Clarissa Pool-Sims, DHCS, said DHCS is ensuring children are placed in the most advantageous program with the least interruption to services. She said the monitoring reports DHCS have been improved to better reflect comments and suggestions received from MRMIB, federal partners, and stakeholders. DHCS is working on releasing a copy of the SPE call statistics.

Mr. Javier Portela, DHCS, said autism has been the largest issue, but with each phase, DHCS has been able to improve on issues from transition.

Dr. Phinney asked about monitoring to ensure the provider networks are adequate. Mr. Portela said, with DMHC, there has been network adequacy conducted for each phase. Phases 3 and 4 are more challenging as families will change health care plans. DHCS will be looking at capacity to ensure families have the ability to choose a physician in the new network.

Ms. Liliya Walsh, HFP subscriber parent, inquired on a process to identify transitioning high risk children. Mr. Portela said plans build a network that is very similar between Medi-Cal and HFP. Most of the complex cases are in the California Children's Services

(CCS) Program; services for those children are provided through the CCS Program and are outside the HFP and Medi-Cal managed care plan. The CCS Program is not impacted by the transition and is still intact, maintaining their coverage, authorizations, and primary physicians. DHCS feels confident high risk children's medical needs will be met and is working closely with MRMIB to receive data on children that may have issues to ensure a safe transition with continuity of coverage. Ms. Walsh asked if CCS will be maintained as a separate program without any changes. Mr. Portela said children in CCS should not receive different services than what they were receiving prior.

Dr. Phinney urged DHCS to monitor plans and their provider networks on an on-going basis, saying it is not unusual for doctors to find their names on provider networks lists when they do not accept that particular insurance. Mr. Portela said DHCS requires signed documents to prove and validate the provider participates in the network. Mr. Schumann, HFP subscriber parent, said he would like to see monitoring on transitioned children is followed up with their physician and are they utilizing services. Dr. William Arroyo, M.D., said the success of the transition should not be measured only by the number of grievances received, as that can be misleading.

Ms. Kristine Marck, California Medical Association, asked who enrollees call to report plan deficiencies. Mr. Portela said they can call the plan itself, the DMHC help line, and the Medi-Cal Ombudsman office. They can also take their case to a State hearing conducted through an administrative law judge, and an independent medical review run by DMHC.

Mr. Sanchez said DHCS is reaching out to the transition group that is changing plans to obtain information about providers. Phase 4 was supposed to be the fee-for-service counties that DHCS now has managed care contracts. Mr. Portela agreed, saying the goal for Phase 4 is that children are transitioned into a managed care environment.

Annual Eligibility Review Process for Non-Transitioned Children

Mr. Sanchez said families with children that have not yet been transitioned must continue sending their Annual Eligibility Review (AER) to maintain coverage.

Mr. Sanchez said HFP families yet to transition in Phase 3 may have to change health plans and providers. AIM-linked infants up to 250 percent of the FPL will be transitioned August 1, 2013, into the Targeted Low-Income Program (TLIP). AIM-linked infants up to 300 percent of the FPL will be transitioned October 1, 2013. Ms. Walsh asked if transitioned children will revert back to HFP if there is a change in income. Ms. Pool-Sims said it is not possible to be re-enrolled in the HFP if income changes, but Medi-Cal has other programs in addition to TLIP. Ms. Walsh asked if income criteria would change for the former HFP children. Ms. Pool-Sims said Medi-Cal is using the same criteria HFP used. The individuals formerly eligible for the HFP will now be eligible for the TLIP. There will be some individuals that will have to pay premiums of $13 per child up to $39 per family per month.

Phase 1A Monitoring/Reporting Plan from DHCS to Centers for Medicare and Medicaid Services (CMS)

Ms. Fei Collier, Project Manager, DHCS, said this report is produced on a monthly basis and is required by and distributed to the Legislature and the Centers for Medicare and Medicaid Services (CMS) for conditional approval of the transition. DHCS applies and adjusts lessons learned with each subsequent transition group. It outlines the number of transitioned children, highlighting annual renewal and information on the HFP and TLIP under Medi-Cal. Ms. Collier also referenced sections on health plans, dental plans, mental health services and alcohol and drug services.

Ms. Pool-Sims stated one concern she hears is the perception that children in Medi-Cal are enrolled one month and then disenrolled the next. Providing information about continuous eligibility to CAA's has helped assure parents their children will be covered. The annual renewal process used now is similar to HFP's. DHCS is taking care to be consistent with documents to avoid disruption and has instructed MAXIMUS, the administrative vendor, to call families and send letters out if their annual renewals are submitted late.

Ms. Karen Lauterbach stated a concern her office would see families whose aid code would be the transition aid code one month and Continuous Eligibility for Children (CEC) aid code the next. Ms. Pool-Sims explained that MRMIB and DHCS were also contacting enrollees and asking if they wanted their documents re-reviewed for 1931(b) eligibility due to the Maternal and Child Health Access (MCHA) lawsuit. There was an influx of documents and some children in the non-premium transition aid code, 5C, were determined to now be eligible for the premium transition aid code, 5D. However, since this was to the child's disadvantage, they were placed in a non-premium CEC aid code. This also happened for children in the premium transition aid code and determined eligible for Share of Cost (SOC) Medi-Cal. Mr. Sanchez noted because full eligibility determination for the 1931(b) program requires the asset test, many families may not have followed through with additional documents and lost coverage.

Ms. Elizabeth Stanley-Salazar, stated the mental health providers she works with have received communications from the Mental Health Care Division, but they have not had any dialog with the Drug Medi-Cal. She emphasized the importance of identifying and coding services received and the children receiving them. Ms. Stanley-Salazar said most of the money from the Substance Abuse Prevention and Treatment (SAPT) Block Grant is spent on the adult system of care and not on the adolescent system of care due to the low number of services available. Therefore, the grant is not a good back up. Ms. Salazar stated that it is critical to monitor and track how HFP children receive services because the list of 1,000 providers may not be accurate.

Dr. Arroyo commented that on the day of transition there was confusion with health plans and specialty mental health plans about who was responsible to pay for services, especially when specialty mental health plans were notified there were a large number of enrollees waiting for them all on the same day. Due to Los Angeles' large network of providers, they were able to handle the influx, but other places in the state with smaller

networks likely had enrollees that did not receive needed services. He suggested a systematic survey must be completed to determine how well the transition went.

Ms. Walsh asked how complaints are being reported, both in number and type. Ms. Pool-Sims stated that the 58 counties having different reporting formats, so DHCS has not yet been able to develop a consistent reporting method. Currently, it is relying upon the Fair Hearings Division. Until the Transition and the Affordable Care Act has been completely enacted, DHCS will not be compiling the complaint data from the 58 counties.

Ms. Janette Casillas, Executive Director, MRMIB, said MRMIB has both a formal appeal process and informal correspondence process. The informal includes a grievance process with health plans. Mr. Portela stated while Medi-Cal plans are contractually required to report grievances filed on a quarterly basis, they have asked plans to report grievances on a monthly basis during transition. Ms. Pool-Sims said reports on are forthcoming. DHCS' current data is anecdotal; they would like more concrete data before compiling a report.

Call Center Report
Mr. Sanchez presented the Call Center Report.

Transition versus Disenrollment Statistics
Mr. Sanchez used this document in comparison with the Call Center Report to show spikes in call volumes were in months HFP subscribers were transitioned to the TLIP.

2012 Application Volumes by Month
Mr. Sanchez presented a close out report of the Single Point of Entry (SPE) activities related to HFP. As of January 1, 2013, DHCS became the sole agency responsible for SPE. He suggested DHCS may present reports like this one on their website soon. Ms. Casillas suggested that MRMIB could provide the chart or data so DHCS could continue with the same format and HFP stakeholders would be able to see a continuation of data. Ms. Pool-Sims said she would welcome the data.

Updated Schedule of Subscriber Notices
Mr. Campana noted the Schedule shows when notices went out to families.

Other HFP Transition Updates
Ms. Collier announced the next DHCS webinar for stakeholder questions on HFP transition will be on July 10, 2013. Past webinars averaged around 500 participants; previous ones are recorded and available on the DHCS website.

Ms. Casillas asked if panel members have been added to the distribution list for the webinar and to specific in-house stakeholder groups. Ms. Collier assured panel members have been added to the distribution list and she would verify being added to the specific groups.

Ms. Collier noted DHCS is working on the second round of the Frequently Asked Questions (FAQs) document for beneficiaries. The first round is available on the DHCS website and was sent to the transitioning families with the notices. In addition, DHCS is working on provider FAQs with the California Medical Association. The next listening session is scheduled for June 3, 2013. DHCS will be submitting the Phase 4 implementation plan to the California Legislature and CMS on May 31, 2013. The Phase 1A and Phase 1B beneficiary surveys have been posted to the DHCS website. Ms. Collier reported 20 positions have been transitioned from MRMIB to DHCS.

Role of the HFP Advisory Panel under Medi-Cal

Mr. Campana provided a brief history of the Advisory Panel. Going forward, the name will change to the Children's Medi-Cal Advisory Panel.

Mr. Campana stated he had a call with Ms. Casillas and Ms. Rene Mollow, Deputy Director, DHCS, discussing the future of the panel. He raised the question of how frequently the panel could meet and if any of the meetings could occur outside of Sacramento. Also, who will be on the panel. Mr. Campana recommended it remain open to the public. Current vacancies need to be filled as those positions were designated by the Legislature. Perhaps the subscriber vacancy should be filled by a full-scope Medi-Cal parent as opposed to a former HFP parent. In asking who the panel should report to in DHCS, he suggested they report to someone with decision making abilities, such as Ms. Mollow or Mr. Toby Douglas.

Mr. Ronald Diluigi, Business Services Provider, asked what was in statute vs. bylaws. Mr. Campana replied only panel existence and representation are statutory. Ms. Casillas recommended the panel draft a memo to Mr. Douglas stating what it can provide him and his executive team. She noted the panel's pushing for greater monitoring and reporting of how HFP subscribers received services and for greater benefits packages for subscribers. It has also provided MRMIB with suggestions on addressing important issues and is the only one with subscribers as panel members. Ms. Casillas stated that MRMIB could assist the panel in creating recommendations, but it must be sent to Mr. Douglas in enough time that he and his team can think about it to have a joint dialog in the next meeting. Mr. Campana asked the panel for input on effectiveness, stating he believes the most valuable aspects of the panel are that subscribers have a voice; that members can go back to their constituencies to provide information; and the panel has made formal recommendations to the Board resulting in new or revised policies and procedures. Mr. Diluigi stated one of the factors making panel effective is MRMIB's executive management attendance at meetings, and they have taken the advice provided by the panel. Mr. Campana agreed the panel needs to be able to reach the DHCS executive team and have them be a part of the process.

Ms. Collier shared Ms. Mollow's request the panel think about frequency of meetings, a new name, and roles and responsibilities - noting the name Mr. Campana gave is suggested, but not final. She also mentioned that DHCS has many advisory panels and is looking to effectively consolidate. Mr. Campana asked if the other panels are enabled

by statute; Ms. Collier replied they are not. Mr. Campana stated the HFP Advisory Panel is in statute and must be treated as such.

To help determine what is unique about this panel, Dr. Arroyo asked what kinds of advisory panels are currently advising DHCS and CHHS. Ms. Casillas told members that no other panel is mandatory and no other panel has subscribers on it. She suggested the panel not think about what other panels exist, but let Mr. Douglas and his executive team make adjustments based on the other panels during future discussions.

Ms. Stanley-Salazar said there was a results oriented approach when working with the MRMIB leadership; transparency and collaboration have gotten results. She believes during transition and implementation of the ACA the panel should meet more frequently and in other places to hear from the public as either a subscriber or provider. When meetings were more frequent and in other cities, public input helped the panel to distill and measure results, support the dental community, and look at important health care community issues.

Ms. Collier provided a high-level, evolving organizational chart of DHCS. The first page is a chart showing different divisions and branches within DHCS. Ones that would be primary contacts for the panel were highlighted and included brief descriptions of duties.

Ms. Lauterbach recommended that a Certified Application Assistant (CAA) be given a space on the panel. Ms. Casillas stated the statute does not designate a CAA position. Ms. Lauterbach also said since Medi-Cal contains a large number of programs for children, the panel needs to define exactly what subjects on which to advise.

Ms. Walsh asked where the panel would be placed in the landscape of the chart. Ms. Collier stated that that would depend upon the panel's recommendations and upon DHCS' executive management team.

Dr. Arroyo noted the panel is subject to the Brown Act, which requires communications must remain open to the public. Therefore, it is difficult to move forward in an efficient manner. Ms. Casillas suggested two ways to move forward. First, develop and present recommendations to DHCS for response at the August meeting. Second, form a subgroup to create a draft to be discussed and finalized at the August meeting. Then DHCS could respond at the following meeting. Mr. Campana recommended taking the second approach and stated only by working with top management can the group have any hope of affecting changes in policies. Mr. Campana, Ms. Walsh and Dr. Arroyo volunteered to have a conference call with MRMIB to create the draft. Draft and discussion time will be on the August agenda.

Dr. Arroyo requested Board input on how the panel has affected HFP. Ms. Casillas offered to reach out to two of the Board members and either get informal input from them, or place it on the agenda for the July meeting for discussion in public session. Mr. Campana noted that every written resolution the panel created went to the Board and he and MRMIB staff would report to Board meetings on major concerns or issues.

Ms. Walsh asked for the statute and Mr. Sanchez provided the code section. Ms. Casillas noted the August meeting agenda will include the statute languages for both the original enabling statute and the transition statute. Ms. Walsh asked if the panel will continue to represent only children who fall in the same income criteria as HFP or if it will represent all children in Medi-Cal. Mr. Campana stated that it will represent all children in Medi-Cal. Dr. Arroyo stated that should be a part of the recommendation process.

Mr. Campana asked what three positions are currently open on the panel. Mr. Sanchez replied the three vacant positions are for a subscriber with a special needs child, a County Public Health Provider, and a Disproportionate Share Hospital Provider.

DHCS March 2013 Survey of Phase 1A Transitioned Children

Mr. Portela stated this survey for Phase IA is a requirement of the 1115 waiver; it is the first of five or six to be completed. For each phase, a statistical calling sample of beneficiaries is chosen and DHCS is attempting a response rate of at least 400 out of every 5,000 beneficiaries called. However, in this first survey, DHCS contacted 10,000 beneficiaries to insure they received at least 400 responses. The survey was not initiated until the group was in Medi-Cal for at least one to two months giving them the opportunity to experience the system. It was conducted through an automated outbound call campaign. The campaign makes five attempts to reach each household and immediately connects to a live operator who administers the survey.

He highlighted some of the lessons learned from the first survey, including expanding the hours for making phone calls to beneficiaries. DHCS also discovered phone numbers provided by subscriber parents were more likely to be accurate and in service than those provided by full-scope no-cost Medi-Cal parents. The survey was designed to be short to avoid parents being on the phone too long. The first survey had only a 3.5% response rate, but since the survey was not incentivized, 3% is comparable to previous surveys conducted. Mr. Portela noted the second survey has been completed, and with expanded hours, DHCS made half the phone calls while receiving one and half times the response rate

Ms. Casillas asked if it was only administered in English. Mr. Portela stated the sample was regardless of language; DHCS has Customer Service Representatives (CSRs) to administer the survey in all 13 required languages. Ms. Casillas also asked for clarification on the legend. Mr. Portela stated survey scripts asked if services received after transition to Medi-Cal were "Better", the "Same" or "Worse" than with HFP.

Mr. Portela noted the first questions were driven by types of services DHCS felt were main areas of concern. The next set was a rating of actual services the subscribers received. The third set asked about changing providers due to transition. The final question was an overall rating of the subscribers experience with the transition. Ms. Collier stated the second survey, for Phase 1B, was posted the morning of the meeting and Mr. Portela added the Phase 1C and Phase 2 are currently being conducted.

Dr. Phinney stated the first question should be changed to look more closely at the subscribers who had not had a doctor's visit in the last year. Mr. Jan Schumman, subscriber parent, suggested asking if the subscriber had to change the provider or health plan. Mr. Portela replied DHCS will take that into consideration in future surveys. Ms. Casillas pointed to the value of the panel's real world experiences with providers and subscribers and being able to give timely feedback, making surveys like this more valuable over time.

Dr. Arroyo noted the question on page 4 of the document may be an issue as the population may not meet the higher levels of need and severity of mental health disorders to qualify for the mental health program in Medi-Cal. Because of this difference, Dr. Arroyo asked for clarification on what DHCS was trying to learn from this question. Mr. Portela stated the survey was intended to be something upon which to build as the transition moves forward and to have the same questions for each of the four major areas of concern so that answers could be comparable.

Dr. Arroyo asked who reviewed the survey prior to administering, and Mr. Portela stated CMS did and he believed it was reviewed by a small group of stakeholders. Dr. Arroyo asked if the survey was for CMS and required contractually; Mr. Portela replied that it was. Ms. Casillas stated she does not believe there was any one with a mental health background to advise CMS on the relevancy of the questions. Mr. Portela stated the survey and monitoring report were specifically designed to meet the requirements set by the California Legislature and CMS. In addition, DHCS will also be producing the Consumer Assessment of Health Care Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS) reports as MRMIB has done in the past.

Mr. David Rivera, subscriber parent, noted that HFP families and CAAs he has spoken to since the transition began have not had similar experiences to those being reported. He asked what number shows up on Caller ID when DHCS makes contact. Mr. Portela said it is a 916 area code. Mr. Rivera stated if the number is a 1-800 number or an area code different than the subscriber's, they may not answer thinking it is a bill collector or a solicitation call. He asked if it is possible to conduct the survey in another way, such as a mailing. Mr. Campana stated mailed surveys are challenging because they often have to be followed up with a reminder mailing and the best method is to send representatives into the community for do face-to-face interviews. Mr. Rivera suggested contacting local agencies or community groups for face-to-face interviews and then forward the results to DHCS. He noted he would have given much different responses to the survey as his daughter was forced to change her primary care physician, her dentist, and eye doctor even though she was able to go to the same optometrist office. He stated families that he has spoken to have had similar experiences to him.

Mr. Potela noted that DHCS is only conducting the survey by phone, but the survey was provided to CAAs to administer over the phone and in person. They created an online forum for the CAAs to report their results. However, the survey results only include the

phone surveys conducted by DHCS. Subscribers were able to make comments that DHCS has looked at, but those comments cannot be reported statistically.

Mr. Campana noted that he had to leave, and turned the meeting over to Dr. Arroyo as acting Chairperson.

Legislative Update

Mr. Sanchez noted that pending bills are included in the meeting packet.

Outreach Update

Certified Application Assistant (CAA) Training

Ms. Pool-Sims provided information on how DHCS is working to connect with the CAAs and Enrollment Entities (EEs). DHCS has hosted two CAA/EE webinars with over 500 attendees. DHCS is gathering information from MRMIB on the database of CAAs and will send out a two question survey asking if they would like to continue being application assistants.

Ms. Staley-Salazar reminded DHCS staff that many mental health and substance abuse providers have federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants. SAMHSA is contacting those providers and asking what they are doing to advocate for their clients. She suggested that admissions offices should also be included in this discussion so that they are prepared to be a part of the navigation system.

Dr. Arroyo asked if the children's advocates are a formal or informal group. Mr. Sanchez stated that HFP, Medi-Cal and Covered California, the new health benefit exchange, meet with the Covering Kids and Families Coalition bi-monthly and mentioned that the coalition includes a number of CAAs and EEs. Ms. Pool-Sims stated that because it is a coalition of advocacy groups they have been a primary avenue of information and provide a large amount of input in writing. Ms. Collier mentioned that this is the group that DHCS provided the survey to and helped to build the training program. She added that this group suggested the inclusion of the Division of Public Health (DPH) for their knowledge of the Women's, Infant's and Children's (WIC) Food and Nutrition Service since it also touches on the health and well-being of children.

Dr. Arroyo asked if Mr. Schumman and Mr. Rivera knew of the coalition and they stated that they did, but were unable to attend the meetings. Dr. Arroyo asked if the CAAs would continue to function. Ms. Pool-Sims stated that they would but as staff and children are transitioned, the materials will be updated to be focused upon Medi-Cal. Mr. Sanchez asked if the online training and certification would continue. Ms. Pool-Sims stated that DHCS intends to once it has been updated with the Medi-Cal information.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grant Update

Mr. Sanchez stated that in 2012 there were six grantees in California with 55 affiliated EEs and the current cycle completes at the end of August 2013. MRMIB has continued to work with them and the last report was made at the end of April 2013 and was on the first quarter of 2013. The report is done in conjunction with DHCS' Information Technology Services Division (ITSD). The report noted that there were 1,700 Medi-Cal only applications and redeterminations and 29,000 HFP/Medi-Cal applications and Annual Eligibility Reviews (AERs) that went through HFP. The next grant application cycle has begun, but MRMIB has been referring the grantees to DHCS for Letters of Support. Ms. Pool-Sims confirmed that DHCS has been providing those Letters of Support to those that have contact them and will provide a copy of one of the letter at the next panel meeting.

Health-e-App Public Access Update

Mr. Sanchez stated that the additional functionalities of the Health-e-App website were launched in English in June of 2012. Those included submitting Continued Enrollment, Program Review, App-a-Person and AER forms. MRMIB is grateful that the website continues to be used since it assists in the AER process for those families that have not yet been transitioned. In addition, the individual users continue to use the website more than those being assisted by a CAA.

HFP Informational Reports

Enrollment Report

Mr. Sanchez referred the panel members to the documents in the packet.

Administrative Vendor Performance Report

Mr. Sanchez referred the panel members to the documents in the packet.

2012 Federal Annual Report

Mr. Sanchez referred the panel members to the documents in the packet.

2012 Survey of Teen Health Care Experience

Ms. Ellen Badley, Deputy Director at MRMIB, presented a newly developed survey of teens in HFP during 2012. Previously, MRMIB used the Young Adult Health Care Survey (YAHCS). However, staff found there is extensive research into risky behavior of teens and determined it would be more beneficial to survey teens about their attitude and experience accessing care. The new survey includes 24 questions in four topic areas: access to care; confidentiality of care; health care experience; and health, safety and wellness of teens. In addition, four questions from the YAHCS survey were included in the new survey for comparison purposes. A random sample of 18,000 teens was selected to receive the survey. To be eligible, teens had to be continuously enrolled for at least six months as of December 31, 2011. The survey found that more than 50 percent of teens indicated that they were able to speak to the doctor alone, an increase of nearly 17 percent from the prior survey. Further, the majority of the time, teens

answered they were told that what was said to their provider would be confidential, an improvement of 16 percent.

Ms. Badley noted that in this report there were significant differences found between Chinese, Korean, and Vietnamese speaking teens. In addition, teens in the Northern region reported experiencing a delay receiving mental health therapy or counseling services nearly twice as often as those in other regions except for the South Coast.

Ms. Stanley-Salazar, expressed concern that teens reported the lowest incidence of communication with their doctors on subjects that are the highest risk for teens (pages 25 & 26). Dr. Arroyo stated that the integration of mental health care and substance abuse services by the primary care physicians will become more important under the ACA. He also noted that he had not seen this kind of information in other reports in California.

Dr. Phinney said that providers often use questionnaires in order to flag concerns of teen patients. Ms. Stanley-Salazar also shared that her office is exploring the use of mobile phone applications for wellness that can help identify risky behaviors in teens.

2011-12 Out-of-Pocket Expenditures Report

Ms. Badley reminded the panel that federal law limits subscriber cost sharing (monthly premiums and copayments) to no more than 5 percent of the subscriber's annual family household income. HFP ensures compliance with this requirement by limiting the total amount of health services co-payment incurred per family to no more than $250 per benefit year. During the 2011-12 benefit years, one family exceeded the 5 percent limit of annual household income and was reimbursed by their health plan. Ms. Badley noted that because premiums were raised in 2009, the number of families reaching the $250 maximum has increased. However, the total number of families represents less than 0.5 percent of total HFP enrollment. This is the final report on out-of-pocket expenditures as a result of the transition of HFP subscribers to the Medi-Cal program.

2011-12 California Children's Services Report

This report presents information on services provided to HFP subscriber under the California Children's Services (CCS) program. In the 2011-12 benefit year, plans referred about 2 percent of enrolled subscribers to CCS, or 19,290 subscribers, an increase from the previous benefit year. CCS accepted about 82 percent of the referrals made by plans. Annual expenditures decreased by about 38 percent from the prior year, but were similar to the costs reported in the 2009-10 benefit year. MRMIB could not determine if this resulted from an anomaly in reporting or a lag in data. Ms. Badley highlighted that the cost per case for HFP subscribers is significantly lower than for Medi-Cal beneficiaries. The average cost per case in Medi-Cal was $14,096 compared to $5,666 for HFP. This is the last year MRMIB will be reporting this data as a result of the transition of HFP subscribers to the Medi-Cal program.

2012 Grievance Report

Ms. Badley stated that each calendar year the contracted plans are required to report the number of grievances filed by HFP families. Like the Department of Managed Health Care (DMHC), MRMIB defines a grievance as any complaint, appeal or expression of dissatisfaction. This year, for the first time, data from the plans was combined with the total number of direct subscriber complaints received by MRMIB in 2012. The overall grievance rate has decreased over the last four years and quality of care continues to be the leading type of grievance. This is the last year that MRMIB will be reporting this information.

Closing

Dr. Arroyo thanked everyone and adjourned the meeting.